The **Solo GP** is Ineffective in the Delivery of **Primary Healthcare** in Singapore Today

Reported by Garfield

"The GP will have to find a niche for himself... The patient is the final judge."

(From left) Dr Tommy Tan, Dr Lawrence Ng, A/Prof V Balakrishnan, Dr Wong Chiang Yin and Dr Wong Wee Nam

The debate held in conjunction with the SMA Ethics Convention on 4 Nov 2000 was chaired by A/Prof Vivian Balakrishnan with Drs Wong Chiang Yin and Wong Wee Nam proposing the motion and Drs Tommy Tan and Lawrence Ng opposing.

The proposition's argued that inherent limitations of solo GP practices cannot meet the demands imposed by rapid societal and epidemiological changes in Singapore. Further, the commercialisation of the doctor-patient relationship and the loss of authority of the GP make solo practice irrelevant. The opposition contended that there are limitations but closer affiliation and co-operation amongst solo GPs can preserve the best that only solo practice can bring. The solo GP was poetically alluded by the second speaker for the opposition, to be a small but warm and bright flame, which must not be allowed to be snuffed out.

PROPOSITION I - LIMITATIONS OF SOLO GPs

Dr Wong Chiang Yin proposing the motion, emphasised that in less than a working life span, Singapore has been transformed from a third world to a first world country. The population has started to grey and the pattern of diseases has altered. These demographic, economic and epidemiological changes have a profound impact on the way we practise medicine.

We are now dealing more and more with the so-called lifestyle diseases such as obesity, myopia, diabetes, hypertension, ischaemic heart diseases and the afflictions of the aged, including cancers, all of which require multi-disciplinary and long term care. Patients' expectations have also grown, not only do they want the best treatment but also rapid and convenient access to health care. Taking all these into account, Dr Wong asked whether the solo practitioner is equipped to provide an effective service to his patients today.

According to him, the solo practitioner is hard pressed to deliver the goods because of certain limitations. The first problem is finance. The overhead of a clinic, especially the rent, has escalated tremendously. Rental for a clinic has breached $20.000.00 per month recently. Since the solo doctor is unlikely to be able to afford very high rents, he will probably practise at an inferior location as compared to that of a doctor in a group practice. He is thus at a disadvantage in the competition for patients because of his poorer exposure and accessibility. Dr Wong said it is no point talking about the effectiveness of a doctor when he does not even have enough patients in the first place.

The second problem is that of manpower. The trend now is for clinics to provide extended consultation hours, some even round the clock. Again, the solo practitioner will be ineffective because he cannot provide such a service without harming himself and sacrificing his social and family life.

Thirdly, a multi-disciplinary approach, as mentioned, is frequently required in the practice of modern medicine. The solo practitioner no matter how clever and energetic he is, without the assistance of in-house colleagues and other health providers will not have the resources, time and the know-how to deal effectively with all the problems that he may encounter. These major constraints will be difficult for the solo practitioner to overcome.

OPPOSITION I - BEST OF INDIVIDUALITY AND GROUP

Dr Tommy Tan for the opposition suggested that the pessimism over solo general practice may have come about because some doctors are not doing well of late. This he attributed to the recent economic crisis and the increase in the population of general practitioners. Also, the impression that solo practice is outdated may be brought about by the setting up of many new group practices and the existing ones expanding and recruiting aggressively.

However, he pointed out, in reality solo practices are far from becoming extinct. He cited the example in Bishan where only 1 or 2 clinics in a cluster of 8 are group practices and in the USA, two-thirds of the doctors practise on their own. This shows that solo practices are still holding their own financially.

Dr Tan, an ex-GP now a psychiatrist, explained why doctors choose to practise solo. Doctors, he claimed, are an individualistic, independent minded and egocentric lot of professionals. They hate to take advice from others, far less criticism. This personality trait is reflected in their behaviour. They prefer golf rather

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than team sports. They do not trust their stockbrokers, and most of them don't stay long whether in group practices or hospitals. In other words, they like to manage things themselves. This disposition is reinforced during their medical training and during work, when most of the time they have to make decisions on their own. Therefore, they do not function well or are happy when working in a group or within a hierarchy.

While conceding that, there are certain disadvantages in a one-man show. Dr Tan said much of these can be overcome. Solo practices, he suggested, can be loosely affiliated while still maintaining their individual identity. They can share staff, contracts, drug purchases, and benefit from economies of scale just like the group practices, and thus have the "best of the both worlds". There are also ample opportunities for continuing medical education and to interact with other colleagues especially now with IT.

Dr Tan concluded that solo practitioners are definitely not endangered species but will continue to evolve and adapt to the changing environment.

PROPOSITION II – ERODING DOCTOR-PATIENT BOND

Dr Wong Wee Nam, for the proposition, argued that the main reason why the solo GP is no longer effective in the delivery of PHC is the fact that the bond between the patient and the doctor is now weak or that it hardly exists. Traditionally, the role of an effective GP is to be familiar with the patient's medical, social and family background and be the overall director of all his health needs, but patients' behaviour have changed.

This is due to multiple factors. People are better educated. There is an information explosion and access to high technology. The population is highly mobile. There is a dissolution of the extended family. Medicine is nearly all commercialised. Consumers' spending habits have changed and patients are increasingly litigious. These changes have together conspired to erode the traditional role of the solo GP and have seriously damaged the doctor-patient relationship.

The doctor has now become a mere service provider and the patient a consumer. The doctor's role as a friend and counsellor has faded. He is no longer the authority whom the patient looks up to. The patient, and not the doctor, frequently decides on his own. The doctor, in order to protect himself, also frequently yields to the demand of his patients or refers them to different specialists. Solo practices, Dr Wong said, is further undermined not only by the high overhead and the fierce competition but also by an expanded role the government is taking on in PHC.

Dr Wong lamented the fact that doctors in solo practices have now lost their "authority", their clinics have become, for all intent and purposes, mere convenient stores, offering only fragmented healthcare services. Perhaps being also a politician, he is more aware than others that a sound and strong relationship between doctors and patients, is essential for the doctor to fulfill his director's role.

OPPOSITION II – SMALL BUT RELEVANT FLAME

Dr Lawrence Ng likened the solo practice to a palm size PC small, yet efficient, although the practitioner has to be rugged nowadays and the returns may not be that attractive. On the other hand, those in partnership may be rich but are often in danger of dying young and anonymously.

Dr Ng said that a solo practice is a long-term commitment, therefore it engages the heart and soul of the doctor fully. This makes a lot of difference with regard to work attitude when compared to the mainly profit-driven group practices. The solo doctor will have to know his patients' personality, idiosyncrasies, social, family and financial background well in order to provide individually tailored healthcare on a continuous basis and to detect any changes quickly. A strong rapport with his patient is *sine qua non*, unlike in a group practice, where doctors change often and both the doctor and patient remain largely anonymous to each other.

The solo practice, he emphasised, is biased for action. In group practices, a lot of time is often spent on meetings and discussions, whereas in solo practices, decisions are made quickly usually involving the patient and doctor only. Management is kept simple. Being his own boss, the solo practitioner can act independently, or as Dr Ng put it, expresses himself freely: anything from deciding on the decor of his practice and the quantum of patients' fees, to participating in the teaching of medical students. The staff too will be more familiar with the personality, concerns and aspirations of the boss, which is good for the practice.

The main problems of a solo doctor of not having enough time, a limited scope of care providing, loneliness and working in isolation can be alleviated by using locum tenens, cooperating with neighbouring doctors, out-sourcing for unavailable facilities and making use of IT.

He also told the audience that doctors in a group practice can be quite quarrel-some, with a lot of energy expanded on politicking and one upmanship and there are also conflicts with non-doctor shareholders who have different sets of values.

Dr Ng dramatically recited a poem in closing, that likens the solo GP to a flame, a small flame, but nevertheless one which gives out warmth and light and he hopes that this flame will never be snuffed out.

The debate was followed by a lively response from the floor. In the heated crossfire, some speakers from the floor amused the audience by their obfuscation as to which side they were speaking for. One of the speakers for the opposition even staged a symbolic 'crossing over to the proposition', quipping in jest that he was after the betrayal even more confused because he was now in the company of real opposition.

A/Prof. Vivian Balakrishnan, the chairman declared the debate a draw. I think his verdict is fair. The points raised by both sides are valid within their context. Ultimately, the GP will have to find a niche for himself. The most important thing is to be a happy doctor, whatever and wherever you are. If one is happy, one is more likely to be effective. The patient is the final judge. ■